Wisconsin Partnership Program Eligibility Questions

1. Who is eligible for enrollment in Partnership programs?

To be eligible, a person must be:

- Age 65 or older (Partnership elder programs).
- Age 55 or older with a disability determination (Partnership disability and elder programs).
- Age 18-55 with a disability determination (Partnership disability programs).
- Certified by the Bureau of Quality Assurance (BQA) as needing care at the nursing home level (ICF1, ICF2, SNF, or higher).
- Financially eligible for Medicaid or the Medicaid waiver program.
- A resident of a demonstration county.

Who may be eligible for these programs?	Partnership Disability Programs	Partnership Elder Programs
Age 18-55 with Disability	Yes	No
Age 55-65 with Disability	Yes	Yes
Age 65 and Over at Enrollment	No	Yes

The Partnership enrollment protocols require that if a person is functionally and financially eligible and interested, he or she must be offered the opportunity to enroll.

2. Do people need to be eligible for Medicare too?

No, Medicare eligibility is not required. While a person may also be eligible for Medicare, Medicare is not a requirement for program eligibility.

3. If someone is eligible for both Medicare and Medicaid, can they enroll in Partnership for just Medicaid without Medicare, or just Medicare without Medicaid?

No. The Partnership program is designed to integrate funding streams so that the Partnership organization can coordinate and provide all long-term care services. If a person is eligible for both Medicare and Medicaid, he or she must enroll in Partnership for both Medicare and Medicaid coverage.

If a person enrolls in Partnership before they become eligible for Medicare, they must apply for Medicare enrollment when they become Medicare eligible. Medicaid eligibility is contingent on using all other available forms of coverage.

4. How is Medicaid financial eligibility determined?

There are three eligibility group mechanisms. Think of them as doorways to eligible status.

***Group A*.**

Some people are *categorically eligible*. They already receive Medicaid through Supplemental Security Income (SSI) and must have had a disability determination from the Social Security Administration.

In addition, there are several SSI-related categories of special Medicaid eligibility, including 503, Widow/Widower, and Adult Disabled Child. These are people who used to get SSI, but lost it when their social security check increased. These cases are unusual and the rules are complex, so consult with a county economic support worker if you find someone this seems to fit.

***Group B*.**

Some people have countable income lower than the special income limit. The special income limit is $1737 per month this year. These people are also automatically eligible, but subject to a *post-eligibility* test for cost sharing. The Economic Support worker calculates personal, spousal, dependent and excess housing cost allocations and determines the final cost share, if any.

***Group C*.**

Some people with countable income over $1737 have medical expenses so high that they become eligible. These expenses must reduce their countable income to less than the *Medically Needy Income Limit*, currently $591.67. This is known as *spending down* to eligibility. For Partnership participants, the monthly medical and remedial expenses are assumed to equal the capitation rate when determining eligibility, but not when determining the *spend down* amount.

Like Group B participants, after determining eligibility, further calculations are needed to determine what spousal and dependent allocations can be made, and determine the final cost share, if any. Group C participants do not receive an allowance for excess housing costs. After these allocations are made, the *spend-down* amount is the remaining countable income that is greater than the Medically Needy Income Limit. The *spend-down* is paid in to the contract agency.

Let's consider some people who might fit into each of these groups. For the following basic examples, assume each person is not married, has no dependents, and has countable assets of $2000 or less.

- *Mr. **A**nderson was disabled since birth and receives an SSI check every month.*
- *Ms. **B**lades receives a pension and social security totaling $1000 every month.*
- *Mr. **C**lark receives a pension, social security, and rents on his duplex totaling $1800 every month.*

5. What assets are exempt from consideration?

Generally, the value of a home (that the participant lives in) and its contents are exempt, as well as one vehicle, regardless of value or purpose. A limited amount set aside for burial including burial trusts, burial funds, burial plots, and burial insurance is also exempt. Other assets -- stocks, trusts, bank accounts, et cetera -- must be considered.

6. What is a cost share? How is it calculated?

A cost share (post eligibility treatment of income) is the monthly amount a Medicaid waiver recipient pays toward the cost of their care, and is determined after basic eligibility requirements are met. Generally, only Group B people have cost shares, but in rare instances Group C people may have a cost share in addition to their spend down.

Cost shares are calculated using the recipient's income, removing allowances for personal expenses as well as some housing and family expenses, and out-of-pocket medical expenses including health insurance premiums.

7. What happens if a member fails to pay cost share?

Failure to pay cost share can result in the loss of eligibility. Partnership agencies collect the full cost share from members each month.

Sometimes, a friend or relative assisting the member to manage finances fails to make cost share payments. If the member is actively pursuing regaining control of his or her money, the member may inform the county that the money is temporarily unavailable. In that case, the member remains eligible until the issue is resolved. Resolution often involves getting a new “rep payee” or guardian arrangement for the member.

If the member (or the member’s relative, guardian, et cetera) is simply refusing to pay the cost share, the provider organization may ask the county Economic Support worker to terminate the person’s Medicaid eligibility for nonpayment of cost share. The Partnership organization then files an involuntary disenrollment with DHFS and EDS based on loss of eligibility. Refer to the Partnership protocol for procedures.

8. Are there other ways to become ineligible for the program?

Yes. A member may become ineligible for a number of reasons, including:

- Absence - Members who are eligible for Medicare may not be absent from the county for more than six months. Members who are eligible only for Medicaid may not be absent from the county for more than one month.
- Level of Care – BQA determines that a member no longer requires care at the nursing home level.

- Incarceration – Medicaid eligibility ends the date the person begins prison or jail incarceration.
- Post-Eligibility Treatment of Income – Members must their pay cost share or liability.
- Assets – Medicaid recipients may not accumulate assets greater than 2000. This may happen when a person inherits assets or saves income over time.

9. What if a member disagrees with the loss of eligibility?

When the county notifies a person that he or she is no longer eligible for the Partnership Program, they will also notify the person if he or she is eligible to receive fee-for-service Medicaid. The county also notifies the person that they must appeal to the Division of Hearings and Appeals within 45 days.

10. Can these programs serve people with End Stage Renal Disease?

It depends on when they first meet federal standards for ESRD (please note rules are somewhat different for PACE). Partnership programs operate under federal "Medicare Plus Choice" regulations. These tables describe the current scenarios for people with ESRD.

Partnership and ESRD	ESRD Scenarios	1	2	3	4
	Medicaid Eligible at Enrollment?	**Yes**	**Yes**	**Yes**	**Yes**
	Medicare Eligible at Enrollment?	**NO**	**Yes**	**NO**	**Yes**
	ESRD Status at Enrollment?	**Yes**	**Yes**	**NO**	**NO**
	Will Medicaid enroll?	**Yes**	**NO**	**Yes**	**Yes**
	Will Medicare enroll?	**NO**	**NO**	**NA**	**Yes**
	ESRD Scenarios	**5**	**6**		
	When did the person become Medicare eligible relative to ESRD?	**Before**	**After**		
	Will Medicaid continue enrollment?	**Yes**	**NO**		
	Will Medicare continue enrollment?	**Yes**	**NO**		
	Will Medicaid enhance Capitation?	**NO**	**NA**		
	Will Medicare enhance Capitation?	**Yes**	**NA**		

11. What happens when a member has other insurance? Who pays the premium?

Some members may pay a premium for third party health insurance. In most cases, the insurance premium can be deducted from income before calculating cost share, spend-down or liability. EDS and WPP must each maintain records of the third party coverage and recover funds from the third party insurer for claims where appropriate.

If a member chooses to stop paying a premium to a third party insurer, two different situations may occur. Some members in group A and some very low income members in group B may gain an equal increase in spendable income. However, for other members using the premium to offset income, cost share (or spend-down or liability) may increase, canceling out or reducing a financial advantage to the member.

In either situation, the Partnership contractor has the option to pay the premium for the client, provided the client consents. It is up to the contractor to manage financial risk by determining if the likely value of the insurance offsets the cost of the premium.

Third party insurance is often permanently lost if premiums are allowed to lapse. Therefore, communication with the member and a prompt assessment of the option to continue paying the premium is appropriate. Additionally, continued access to the third party insurance may be very valuable to the member in the event that he or she becomes ineligible for Medicaid (for example, by inheriting assets or substantially increasing income).

12. What about “Medigap” policies?

If a member already has Medicare supplemental insurance (popularly known as Medigap) before enrolling in Partnership, he or she may currently keep the coverage and continue to report the premium as an out-of-pocket medical expense. This preserves the benefit for later use, should the person disenroll from Partnership.

However, it is seldom possible to use the coverage while enrolled in Partnership. It is not legal for an insurance company to sell a new Medigap policy to a person receiving Medicaid.

13. How do spousal impoverishment protections work?

Federal legislation passed in 1988 protects some income and assets for spouses of married Medicaid waiver and institutionalized recipients. There are specific limits on the amount of income that may be allocated.

Assets may also be allocated to a community spouse. The recipient's amounts combined with the spouse’s own assets may not exceed the spousal asset limit shown below. These

assets must actually be transferred from the recipient to the unserved spouse within twelve months, or the recipient will lose eligibility.

If the couple's total countable assets are:	The (unserved) community spouse can keep:
$0 - 50,000	All
$50,000 - $100,000	$50,000
$100,001 - $190,200	Half of combined assets
$190,200 or more	$90,660

When both members of a couple receive care, spousal impoverishment protections do not apply.

14. If someone has been separated from their spouse for a period of time, can they benefit from spousal impoverishment?

Yes. The income allowance may be a bit larger if the spouse maintains a separate household (due to an additional housing allowance).

15. What can be done with assets if they are greater than the $2000 limit?

Applicants may establish burial trusts. Remaining funds should be used to support the cost of care and living expenses until the person becomes eligible. This might include home maintenance and modifications to better suit their daily living needs.

If a previously eligible person inherits or otherwise acquires money or other countable assets in excess of the $2000 asset limit, eligibility may be lost. Applicants or recipients may pay excess assets in to the Department of Health and Family Services to establish or maintain eligibility. This is another area where the county economic support specialist should be consulted.

16. What is the word on divestment?

This is when a person transfers assets to avoid using them to pay for the cost of their care. MA regulations say that divestment is the transfer of resources by an MA applicant or recipient or recipient's spouse for less than fair market value. If someone does this within three years of applying for Medicaid, their eligibility for Medicaid coverage of hospital, nursing home, or waiver program expense is delayed (although they may receive Medicaid coverage for other fee-for-service expenses). The amount of delay is determined by dividing the total fair market value of the transferred assets by the monthly private pay nursing home rate.

For example, Mr. Jones had $42,000 in savings, but in March 1998 he gave $30,000 to his daughter. Over the last year he spent $10,000 on health and personal care. This leaves Mr. Jones at the **Medicaid personal asset limit of $2000**, so he applies for Medicaid. If the private pay nursing home rate is $3000/month, Mr. Jones is ineligible for the Medicaid waiver program for 10 months. The penalty period begins with the month of divestment.

17. What changes when a member is placed either temporarily or permanently in substitute housing?

During temporary stays, the member is allowed to maintain his or her home or apartment. Partnership considers treatment or rehabilitation placements temporary if the stay is not expected to exceed three months. When a recipient is temporarily institutionalized, only the funds the recipient wants to contribute to the cost of care may be applied to institutional costs. The person generally does not have to pay a liability during a temporary stay in a nursing home. However, if the recipient manages to accumulate savings in excess of $2000, Medicaid waiver eligibility is compromised.

When a member permanently moves to an institutional setting, he or she must *generally* use their income to pay the institutional liability, and may no longer use income to maintain the home. If an institutionalized member sells a home and receive cash in excess of the asset limit, he or she may lose Medicaid eligibility and be disenrolled. However, the member has the option of paying the money in to the Medicaid program to maintain eligibility and remain enrolled.

When a member permanently moves to an institutional setting, but his or her spouse remains in the home and does not participate in a waiver program, spousal impoverishment protections may apply. If the community spouse is a Medicaid waiver recipient, however, spousal impoverishment does not apply. In the latter case, the community spouse may not have sufficient funds to maintain the home or apartment.

18. Are there special housing issues for SSI recipients?

When an SSI recipient resides in a nursing home for more than three months, they lose their SSI income. SSI recipients in less restrictive group residential arrangements (or their authorized payee) must report recipient living situation to the Social Security Office to assure the appropriate level of SSI income is paid. SSI income varies depending on living arrangement. Failure to report living arrangement appropriately may result in income recoupment by SSA.

19. What about households where other people live? Whose expenses are whose? What if the homeowner is permanently placed in a nursing home?

There are multiple answers to this question, depending on whether any of the residents fall into some special protected class. This is an area where it is important to work with the county economic support specialist for a determination.

20. How does Partnership eligibility differ from Nursing Home eligibility?

Wisconsin Medicaid waiver eligibility rules allow for the recipient to retain a personal allowance to maintain their household, buy groceries, etc. If a Medicaid Waiver recipient is permanently institutionalized, they lose their waiver eligibility and fall under Institutional Medicaid rules. Institutional Medicaid rules require that the personal allowance be limited to $45 for a nursing home resident (or $65 for a CBRF resident), with the remainder of income going to the patient liability for care.

When a person enrolls in Partnership, the Wisconsin Medicaid waiver rules are applied. However, unlike other Wisconsin Medicaid waivers, the Partnership Medicaid waiver allows the program to continue to provide care in institutions. When a recipient permanently enters institutional care, the county economic support worker applies institutional Medicaid rules. Partnership pays the Nursing Home or CBRF costs and collects the patient liability less the personal allowance from the recipient.

21. When a Member resides in substitute housing allowed by the COP or CIP waivers, who pays for what?

The Partnership agency is responsible for the monthly cost of the substitute housing. The member must pay cost share to the Partnership agency as determined by the County Economic Support Specialist.

22. What is a Quimby? When does Medicaid pay for part B of Medicare?

QMB (commonly pronounced Quimby) stands for Qualified Medicare Beneficiary. QMBs are people who, because of certain eligibility criteria, have Medicaid pay for their Medicare premiums. People eligible as a QMB do not have to pay Medicare co-pays and deductibles.

A person is QMB eligible when:

- The person is entitled to Medicare Part A,
- Their income is less than 100% of the Federal Poverty Level (FPL), and
- Their assets do not exceed twice the SSI asset limit.

Additional Medicare premium buy-in programs include SLMB and ALMB. The rules and benefits are somewhat different from QMB. Contact your county economic support worker or the local Social Security office for information.

Medicaid recipients who pay their own Medicare premiums have the premium amount removed from their countable income when determining cost share.

23. How is the capitation rate set?

The Medicaid capitation rate is based on at weighted average of the following factors:

- The Medicaid cost of nursing home care plus the average cost of additional Medicaid fee-for-service expenses for nursing home residents in the target group (for example, elderly or physically disabled) in the county. Expected patient liabilities and third party liabilities reduce the rate.
- The Medicaid cost of home and community-based services (HCBS) care plus the average cost of additional Medicaid fee-for-service expenses for HCBS recipients in the target group, in the county. Expected patient liabilities and third party liabilities reduce the rate.

The average cost of these two factors, weighted by the proportion served in each setting, is combined and discounted by 5% to ensure cost savings to the State.

The Medicaid capitation rate is further adjusted for enrollee age, Medicare status, and level of care. Payments are based on assumptions about the relative proportions of each age group, Medicaid-only versus both Medicaid and Medicare, and the level of care. At the end of the year, the assumed case mix is compared with the actual case mix, and funds are transferred between the state and the contractor to reflect the final rates.

At this writing the Medicare capitation is the Medicare “rate book” in the target group in the county, multiplied by 2.39 to adjust for a frailty factor.

24. What is Estate Recovery? Do Partnership members have an estate recovery liability?

Estate recovery is the process by which the Department of Health and Family Services recovers some of the costs of providing care. Estate recovery occurs only after a beneficiary is deceased, when the state places a lien on the beneficiary’s home or other assets. Some protections for surviving household members may delay collection of the lien. Cost share and liability payments will not reduce the estate recovery obligation, as the capitation fees are set “net of cost share”.

Estate recovery laws do not apply to Partnership at this time.

25. What disclaimers must follow the information in this document?

All numbers and many of the facts included in this document change over time. Always check to make sure you are using the current information when estimating eligibility, cost share and spend down. When in doubt, ask your friendly county economic support specialist!

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